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LIMITED RESPONSIBILITY.[1]

A DISCUSSION OF THE POMEROY CASE.

BY CHARLES F. FOLSOM, M. D.

In speaking of the duty of the expert who is called upon to testify as to the insanity of any individual who has committed a crime, Conolly says, "His business is to declare the truth; society must deal with the truth as it pleases." Westphal, Meynert, and Maudsley have reiterated this opinion, and, keeping it in mind, I purpose discussing briefly the case of Jesse Pomeroy, convicted of murder by a Massachusetts jury, and sentenced to be hanged.

Either the boy is insane or he is not; and he cannot be said to have something of this disease and something of that, and some of the symptoms of still a third; but his malady, if such it be, must be one of the well-recognized forms of mental disease; that is, just as in any other diseased condition, the first step is to make an exact diagnosis. Of these manifold forms of disease, there are only five which, as far as I know, have been considered as the morbid processes under which Pomeroy was acting when he committed murder, and these are —

(1.) Delusional insanity. (2.) Insanity from masturbation. (3.) Epileptiform insanity. (4.) Moral insanity. (5). Moral imbecility.

The first is the commonest form of disease under which crimes are committed. In well-marked cases the diagnosis is so easy that any one may make it, while in mild cases it is often so difficult as to baffle the most expert alienist for weeks, inasmuch as a shrewd and intelligent man may effectually conceal his delusions for a long time. Such people are generally able to control themselves to a considerable degree, and often when the disease is quite pronounced; that is, under ordinary circumstances, with ordinary inducements, they can resist ordinary impulses. A cigar after dinner, or a glass of wine, may be sufficient to restrain one of them from smashing his windows or throwing chairs at his physician's head; but suppose that a strong inducement to crime comes when he has an excellent opportunity of getting what he con-

[1] Read before the Health Department of the Social Science Association and the Suffolk District Medical Society, Boston, December 16 and 18, 1875.

siders a great advantage to himself at only the cost of killing another man, his self-control is a mere nothing. Sometimes these patients recognize and acknowledge the fact that murder is wrong for them and for all people; sometimes, and that more commonly, they think that it is wrong in the abstract, but that there are special circumstances which make it right for them.

I can call to mind a number of such men, who used to say that they were insane, and not responsible before the law, and that they should therefore commit such and such acts of violence, which they would proceed at once to do. Three of these patients — a physician, a naval officer, and a merchant — I have reason to remember quite well; and a gentleman formerly in the McLean Asylum, using this argument, once made a deadly assault on the late Dr. Bell, who fortunately escaped with only a scalp wound.

Again, the moral sense is often so keen, and the intellect so clear, with many of them, that they will take great precautions so as not to allow their delusions to get the upper hand of them. A gentleman far advanced in convalescence once, while eating his dinner, threw his knife and fork violently through the window, and then calmly turned around to my friend standing at his side, and said, "I wanted to kill you, and I should have done it if I had n't thrown them out of the window."

It is especially with reference to this class of the insane that the remark has been made that people do not cease to be men and women in becoming insane. There can be no doubt, and it is quite well acknowledged, that patients with delusional insanity do sometimes commit acts of violence from the same motives which actuate ordinary criminals, and with sufficient power of self-control to have restrained them. I know, however, of only one case where experts have held this opinion in court. Nevertheless, it is almost without exception beyond the power of human insight to say in what cases they act in virtue of their insanity and in what they do not; and therefore, once granted that any insane individual has definite delusions, I think that there must be very few physicians who have seen much of the disease, who would under any circumstances hold him fully responsible for a crime which he may have committed.

The idea that Pomeroy may be suffering from delusional insanity has now been quite generally abandoned. No delusions have been found, and a person of his limited intelligence could not have concealed them had they existed.

The case of Blampied was one of this kind. He was discharged, as recovered, from an insane asylum upon the certificates of four experts, of whom three were officers of the asylum, and the fourth was in practice in the town where Blampied lived.

At his trial for a murder which he committed some years after leaving the asylum, and apparently from ordinary motives, no expert testimony was called.

The superintendent whose patient Blampied had formerly been, gave his written opinion as to his recovery, complaining of that very fact, that no expert opinion had been asked during the trial, and stating that Blampied should be hung, not as an insane though responsible man, but as a sane and responsible one; and so far he seems to me to be right.

To make his position stronger, he also said that even in the asylum, Blampied never belonged to that class of the insane who lose their self-control to a great degree, which was perfectly true. His opinion also was that if Blampied had committed a murder while there, he would have been properly held fully responsible. In that I cannot agree with him. My only object in citing the case originally was to show that there are alienists who think that the doctrine of non-responsibility has been pushed too far.

Not very long ago, Mr. J., an insane Scotch clergyman, attempted to commit rape upon a young maid, and afterward on a young lady. Two of the first authorities in Scotland testified in court that the gentleman was suffering from well-marked mental disease, that he knew that the acts which he had attempted were wrong, that he had sufficient self-control to have restrained him from so doing, and that there was no reason why the law should hold him to a limited degree of responsibility in these cases.

On May 21, 1873, Mr. Lutwidge, while visiting one of the asylums of England, in discharge of his duty as one of the commissioners in lunacy, was struck on the right temple by a patient, with a nail. He died from the effects of the injury a week later. I quote the following passage from the official report[1] published a year after Mr. Lutwidge's death. In speaking of the patient, the commission, composed of three physicians and three lawyers, say, "He was well known to those members of our board who from time to time during that period had visited the asylum where he was confined. . . . Those of our number who, as just mentioned, knew the man, describe him as being a person of a weak, imperfectly developed intellect, but they agree in considering that he was quite responsible for his actions."

Last September, a patient in one of the large asylums of England killed an attendant against whom he had long had a grudge. He stabbed him in the back with a table-knife. The superintendent of the asylum and several other alienists have maintained his responsibility for the act. They say that the insane hear of such cases as the unfortunate one of Mr. Lutwidge, and become emboldened to commit crimes which they would not think of, provided they did not know that the law

[1] Twenty-Eighth Report of the Commissioners in Lunacy for England, page 2.

would hold them irresponsible. This opinion, of course, is open to criticism.

As to the second head, masturbation is common in the insane, and is one of the many symptoms of loss of self-control and self-respect. As a *cause* of insanity it is rare, so rare that many doubt its existence. The prognosis is generally about as unfavorable as it well can be, and the disease is progressive, that is to say, dullness, moroseness, ill-temper, and suspicion are followed very rapidly by loss of memory, considerable diminution of the intellect, and some loss of flesh, not infrequently emaciation. Such patients complain of headache, a symptom to which I do not generally attach much importance, as I find it so common, especially in boys who attend school in badly-ventilated buildings. The characteristic symptoms of this disease are certainly not found in Pomeroy.

In these cases, too, there is not often difficulty in ascertaining the fact. Often the patient will use his thighs, if his hands are tied. I should doubt the existence of this form of disease in all cases where there was any possibility of the existence of a doubt as to the habit. When it is actually persisted in to such a degree as to cause insanity, the victim has lost self-respect and self-control in too great a degree to render concealment possible. We all know how common this vice is in prisons, in reform-schools, in industrial-schools, etc. We seldom see insanity come from it.

As to the third form, Maudsley states that in epileptiform insanity the sufferer is just as unable to control himself as is the man who tumbles to the floor in tonic and clonic convulsions, and justly says that it would be as fair to punish the one as the other. Pomeroy, however, has been perfectly able to control himself while under observation at the reform-school and at the jail. Yes, more, the presence of a third person has always been sufficient to restrain him from committing crimes or acts of cruelty.

I do not think, either, that the amount of deliberation and calculation shown by him is compatible with the diagnosis of epileptiform insanity, although it would not invalidate the diagnosis of other forms of mental disease; and I should say that, in this case, the absence of forgetfulness is a symptom which is of considerable importance. Finally, epilepsy in all its forms, in the immense majority of cases, especially where there is no medical treatment, is progressive. If anything, the contrary is true with Pomeroy.

Fourthly, the discussion of moral insanity is comparatively simple. Pomeroy does not deny that he knows that the acts committed by him were wrong; and I do not suppose that any one will maintain that he lost his knowledge of right and wrong just when he committed the murders, and at no other times. This question resolves itself, then, into the

inquiry whether he was acting from a temporary impulse against which he was powerless to contend. This is a well-recognized morbid condition, both as a disease and as a stage of disease, and that too while the intellect remains perfectly clear. It has been described again and again from Pinel's day down. The Germans say that the patient acts from a *Trieb*, that is, from something which drives him on, in spite of himself. People who know that it is wrong to lie, and who are most conscientious and upright when well, will fabricate the basest falsehoods; others will steal, and others will commit acts of violence. These impulses are by no means as uncommon as most people would suppose. Fortunately for society, the three conditions necessary for the commission of crime under them — the impulse, the opportunity, and the lack of self-control — do not very often coincide in point of time. A milder form of this morbid condition, the homicidal idea, or the idea of doing wrong generally, is very far from being uncommon.

Alienists, especially those with what Herbert Spencer calls the theological bias, have denied the existence of moral insanity, but all must acknowledge that the brain is necessary for all intellectual and emotional manifestations; and it is only a step further to the position that a variety of organs are necessary for a variety of manifestations. Given these various organs, of course any one of them may be diseased, while the others remain sound. It is tolerably certain that different ganglionic cells in the spinal cord have different functions; and many clinical observations, especially the symptom aphasia, make the same fact more than probable with regard to the brain. At all events, the authority of Pinel, Marc, Ray, Maudsley, Tuke, Bucknill, Morel, Esquirol, and many others is conclusive on this point.

I saw not long ago a man with this disease. He had killed his superior officer. In prison (he was too powerful to be in an asylum), he had stabbed one fellow-prisoner, had bitten off the lip of another, and had tried to kill his physician by throwing a heavy stool at his head, and at all these times when the odds were entirely against him, as there were plenty of officers about. I think that this form of disease must be excluded in Pomeroy's case for the following reasons: —

(1.) There was too much premeditation in the acts committed by him.

(2.) The boy could exercise self-control while under observation.

(3.) There was a motive in his acts, in his love of torturing; for I do not think that he ever meant to murder; and experience had taught him that up to that time, at least, he could enjoy his horrible sport without undergoing anything that was really punishment to him.

Cases of moral insanity get into asylums for the insane, but neither confinement there nor punishment (which latter has usually been first tried at home) ordinarily does any good. If the patient cannot steal

anything he likes, he will steal at least *something;* if he cannot attack a boy, he will make an attack upon an attendant.

Fifthly, I have for the sake of definiteness considered moral insanity and moral imbecility separately, although they are commonly confounded. Dr. Ray discriminates carefully between the two. I suppose the latter of the two terms in a certain sense covers the meaning of the gentlemen who think that Pomeroy is weak-minded.

Moral imbecility may affect the intellect also, and exist in every degree up to complete idiocy, the only form of insanity that is at all common before puberty. In fact, as Maudsley says, even mania so early in life may be generally described rather as excited idiocy.

Every child (to take an extreme case) recognizes the mimetic creature of a spinal cord and cerebellum who kills a baby because he has just seen a butcher kill a calf, and without being able to see any difference between the degrees of criminality of the two acts.

Jesse Pomeroy, unlike an idiot or an imbecile, seems to me a boy who has had his wits sharpened by contact with the many people who have examined him, and who has shown a considerable degree of skill in his attempts to make his case a plausible one for executive clemency.

Dr. Ray describes the moral imbecile as torturing children from the same motive which makes a cat torture a mouse before killing it. He does not know that his acts are wrong, and he does not forget them. Like the cat, to continue the comparison, he makes no attempts at concealment and feels no remorse. Cat-like, too, he will sometimes direct attention to what he has done.

Granting, however, for the sake of the argument, that Pomeroy is not responsible, the position does not seem to me at all tenable that his confessions and retractions and contradictions merely embody the uncertain and incoherent ideas of an insane person. If such were the case, they would be indications of so great disorder of the intellect that the insanity would not fail to be easily apparent; for these symptoms, like cough and night-sweats and emaciation, are evidences of well-marked disease.

At best, I do not see how the boy can be called anything more than weak-minded. This term I should use as being in a measure synonymous with moral imbecility, differing from it in degree only. I should not, however, consider it as an initial stage of that disease, nor should I hold that it indicates sufficient deviation from the normal type to place the sufferer from it outside of the pale of ordinary criminals. Of course he is weak-minded; every criminal is weak-minded, every man is weak-minded who deliberately places himself in opposition to any well-organized society. Any one else must know that in the long run it does not pay. The question for us to decide is whether Pomeroy is any more weak-minded than the whole criminal class.

No one can doubt that disease and crime are closely allied. The criminals with insane and consumptive parents, and the many who themselves become insane or consumptive, must alone convince us of the fact. In the cells of the penitentiary one will see the imperfectly developed ear, first pointed out by Darwin as a mark of inferior organization, as often as he will in Westphal's wards in the Charité.

Dr. Manning in his Report on Lunacy (page 221) says, "At Millbank and Perth prisons, special wards are set apart for epileptic and weak-minded criminals. The former require some extra watching; and the prison routine, especially where isolation is practiced, is thought to conduce to absolute insanity in the latter. Both classes are, therefore, kept apart from the ordinary prisoners, in large, well-ventilated wards; work, eat, and drink in common, and sleep either in cells or dormitories, as seems most fit. The number of these cases at Millbank (1868) is nearly two hundred," that is, nearly one sixth of the whole.

Last September, in the famous Millbank prison there were sixteen suicidal convicts who required watching day and night, and three more were so desperately bent on self-destruction that they were kept in padded rooms. It must be borne in mind in this connection that there is in England, as there is also in Scotland, a special asylum for the criminal insane.

Weak-minded people abound everywhere. As boys, they run away from home or from school, and do a host of things that vex the saint and puzzle the psychologist. As men, they perhaps have abundant energy but lack steadfastness and definiteness of purpose, or they fail to carry out plans well laid, for want of perseverance and ability to make the necessary continuous effort. Society says that they have been failures, but they are just the people who, if they fail to get the healthy influences of sound educations, form our criminal class.

In boyhood, punishment sometimes cures them; in youth, if they are sent to insane asylums, that often cures them because it is simply a punishment, and they regard it as such; if their friends, too, tell them plainly that they can have their liberty as long as they behave well, but no longer. We may not expect the club-footed boy to run, but he can stand or walk, and may strike out from his shoulder a blow that will knock you down.

I suppose that it is under this head that Pomeroy's attempt to escape from the prison is described, as one not showing much judgment, and as being one such as is often seen in insane asylums. It is worth while to stop a moment and consider this statement; Pomeroy's plans were as well laid and as judiciously carried out as the average of such attempts in the State Prison at Charlestown, the immense majority of which have ended in just as signal failure.

Lately, three men have tried to escape from the prison where Pom-

eroy would be confined if sentenced for life, and in the face of what are ordinarily called impossibilities. One broke his thigh after jumping twenty-six feet from a roof of one of the work-shops to the prison wall, and was captured after rolling over and over some rods away; the second was taken after a short run; the third escaped entirely.

A gentleman of Boston, not a physician but a sound psychologist, saw Pomeroy in his cell. Upon being asked whether he should commit murder if allowed to go out, the boy said, in a swaggering way, "Oh, I don't know; I could n't say whether I would or not." In reply to a question concerning what he was in the habit of reading, he said, in the same manner, "Oh, I like the blood-and-thunder stories in the newspapers better than anything." When visited by a member of the Board of State Charities, who has been familiar with his history for several years, he said, "I suppose I did these things — they say I did," although at other times he made no pretense to any forgetfulness. My ideas of a moral imbecile are certainly something very different from this.

I cannot see, then, that there is any evidence of Pomeroy's insanity, except in the horrible character alone of the crimes which he committed. This has been somewhat insisted upon in his case; but alone, without other symptoms, it is really no evidence of insanity whatever. If we allowed it to be such, we should, as Westphal well says, be only opening the door to excuse every criminal.

The absence of remorse, too, has been considered a strong argument in favor of the boy's insanity; but that could not be insisted upon by one who had spent much time in prisons. General Chamberlain states that remorse is an unusual emotion among convicts, except with that class of them who have committed crimes from impulse, while under strong temptation, or under the influence of alcoholic liquor, etc. The same observations have been made by others.

Jesse Pomeroy, then, it seems to me, is responsible for the crimes which he committed; not as fully responsible as you and I would be, but yet responsible before the law. In fact, if we could measure nicely, no two of us would probably be found who could justly be held to precisely the same degree of responsibility.

And here I would say one word as to the object of punishment. Of course, the first idea was revenge; the next was a step higher, and is generally called justice: "an eye for an eye, and a tooth for a tooth." But with the thinking classes, who have been again and again disappointed in their hope to see some reformatory method successful enough to become general, and who judge dispassionately, the real motive in punishment of criminals is the protection of society.

Leaving out the general question of the advisability of capital punishment as not belonging here, is it fair to suppose that anything else

than death will protect society from such a monster as Pomeroy, when the chances of escape from prison are so many, and when we know that out of 266 men sentenced to imprisonment for life at Charlestown from 1828 to 1875, 135 have been pardoned? From the adoption of the constitution in 1780 to the year 1875, 137 persons have been convicted of capital offenses in the Supreme Court of Massachusetts; of whom 76 were executed, 25 were pardoned, 34 had sentences commuted, and 2 died in prison.

I have not seen the accounts of the horrible deeds recently committed, and quoted at a late meeting of one of our medical societies, and I have not had the time to investigate and consider them carefully enough to form opinions in regard to them. I should not, however, consider it safe to base my diagnosis upon the accounts in the daily papers.

It seems to me, too, that the average bad boy does fully as wrong things as to throw stones at his mother and then tell her that he is sorry for it.

I read in the London *Times* a few weeks ago an account copied from the St. Louis *Globe* of the trial of a midwife who delivered women and "disposed of" their babies. She was in the habit, as shown by indisputable evidence, of throwing the infants, dead or alive, into a stove and burning them up. What possible motive, you may say, could such a wretch have in killing with so much cruelty, when it was just as easy to do it without inflicting pain or causing suffering?

Crimes of a horrible character have been fearfully frequent of late, especially in Italy and the United States, in both of which countries punishment for crime has become lamentably uncertain. I think that this terrible danger to society can be removed; but, to quote the words of one of the first alienists now living, it is necessary in order to do it to hang some of these murderers.

After having tried all sorts of treatment for criminals, the so-called "humane" and others, England has finally settled upon the "stern and deterrent system" approved by Chief Justice Sir Alexander Cockburn as the best; and, according to Major Du Cane, Inspector-General of Prisons, it has already begun to have its effect in reducing the number of commitments for crime. I fully believe that the stern treatment would have upon boys of Pomeroy's class the same effect which the return to the use of the lash on the bare back had on the garroters of London.

Among the experts who have seen Pomeroy, and consider him irresponsible, there are two opinions on this point: —

(1.) That punishment would have no effect upon him or upon others of his class.

(2.) That punishment would deter them from crime, but that the same thing might also be said of a considerable proportion of the inmates of our insane asylums.

A CASE OF PELVIC HÆMATOCELE.

BY F. GORDON MORRILL, M. D., OF BOSTON.

NOVEMBER 6, 1874, I was asked to see Mrs. F. C., twenty-four years old, whose previous history was as follows: —

She had been married two years, and her previous health had been good until the commencement of her present trouble. Her only child had died of uncontrollable epistaxis about a year before. On the 6th of the preceding month menstruation (which had been perfectly normal) was followed by a purulent discharge, of offensive odor. She positively denied having ever miscarried, or having been at all subject to menstrual irregularities. On October 25th the discharge ceased, and an attack of dysentery followed, which lasted a week. November 3d she ventured out, and menstruation (or something which resembled it) came on while she was in the street; it ceased immediately after she arrived at home. Very shortly after this she began to suffer from intense pain in the abdomen, which continued with occasional intermissions up to the date of my first visit.

I found my patient in bed, with her body bent forward; she was flowing slightly. Aside from tenderness on pressure over the lower part of the abdomen, nothing abnormal was discovered after careful examination. The usual treatment for suppressed menstruation was advised, with morphine to relieve her pain.

November 7th. The flow was slightly increased, and the pain continued when it was not controlled by morphine.

November 8th. I was summoned in haste, and found the patient in a state of collapse: the pulse weak and intermittent, the respiration sighing, the extremities cold, and the countenance of a death-like pallor. From this condition she rallied under the influence of stimulants and hot outward applications. Another examination was made, and nothing was discovered which furnished the slightest clew to the cause of her alarming condition, although I strongly suspected what afterwards proved to be the true nature of her trouble. She was still flowing slightly, and this continued until the 18th, when a tampon was inserted, and tinctura ferri chloridi and fluid extract of ergot were prescribed.

December 8th. The tampon had been used three times since the preceding date, but with very poor success, the flow returning in each instance within three or four days after removing the sponges. A spongetent was now inserted.

December 9th. The finger could be readily passed up to the fundus of the uterus, which was empty. No particularly tender spot was discovered in the vagina. No swelling of any kind existed. The pain in the abdomen had continued, with occasional intermissions, since the commencement of her sickness.

December 10th. Since the preceding day a rounded tumor had appeared in the left iliac region, about the size of a large apple. It was solid to the touch, and flat on percussion. Dr. Minot was called in consultation, and a sound was passed into the uterus. Its point could be distinctly felt by the hand placed upon the tumor, when the handle was depressed. The sound entered four and a half inches. Behind the cervix an elastic egg-shaped swelling was detected, its long diameter being lateral.

December 22d. Since the last report the swelling behind the cervix had doubled in size, and the os uteri was crowded forward and flattened against the pubic bones. Externally there was a very large and ill-defined tumor. Since the 9th very little flow had been present, but a purulent discharge had taken its place. Meanwhile the patient had lost strength, in spite of supporting treatment and the administration of internal astringents.

December 27th. Nothing like fluctuation had been detected, but from the history and rapid increase of the swelling, its fluid nature was strongly suspected. Much difficulty was experienced in expelling the contents of both the bladder and the rectum, and operative measures were decided upon.

December 28th. Drs. Minot and Bixby in consultation. The tumor, which had now descended below the os uteri and occupied the entire vagina, was first punctured with an exploring needle, and then (the diagnosis being confirmed) quite a free incision was made, giving exit to about a pint of bloody serum and a few pretty firmly organized clots.

The patient rallied well from the operation, and the cavity was washed out twice daily with a solution of carbolic acid in strong castile soapsuds, which was injected by means of a fountain-syringe with a double nozzle. At first the discharge consisted of clots and serum only, but it soon assumed a purulent type. After January 16th no clots appeared, and the injection (now changed to a solution of permanganate of potash) was given but once daily. After this time the wound was kept open by daily dilatation. The original depth of the cavity was about six inches.

February 3d. The cavity was now but one and a half inches deep, and the discharge consisted of serum only; the wound was allowed to close. Meanwhile the patient had steadily improved under tonics and stimulants. On February 4th menstruation occurred, all the attending phenomena being perfectly normal. The patient has enjoyed perfect health up to the present time.

The chief point of interest in this case is the obscurity of the symptoms, no tumor being present until thirty-three days after what had seemed unmistakable signs of internal hæmorrhage. The difficulty in making a positive diagnosis was still further increased by the suspicion

that an abortion had been produced, — the purulent discharge following menstruation (?) in October, succeeded by an attack of dysentery, which could very well have been caused by some drug given to excite uterine action (oleum sabinæ, for instance), rendering the suspicion justifiable, notwithstanding the patient's positive denial when questioned.

AN INSTRUMENT DESIGNED FOR THE TREATMENT OF UTERINE CATARRH.

BY CHARLES L. PIERCE, M. D.

In the treatment of catarrhal inflammation of the uterine cavity, a very efficient means of relief and in many cases of radical cure is lost to the general practitioner on account of the dangers that have attended its use. Indeed, the practice of injecting medicated fluids into the cavity of the uterus has so often been followed by such alarming and fatal results that we find our best writers on diseases of women, while acknowledging the good that might otherwise be derived from it, hedging the operation about with so many warnings of danger that only the expert gynæcologist would dare resort to it. Thus, Thomas says that he 'strongly recommends the general practitioner who is unfamiliar with the treatment of uterine disorders to avoid its use entirely, except in cases of uncontrollable hæmorrhage in which the cervix is well dilated and no flexure of the uterus exists.

It is generally conceded that the disastrous consequences resulting from injecting the uterus are mainly due to the retention of the fluid within its cavity. For, when the cervix is well dilated and there is no considerable flexure of the organ to interfere with the rapid escape of the fluid, the uterus may be injected, not only without danger, but with benefit. It follows, then, that any device that will facilitate or, better still, render certain the escape of the injected fluid is worthy of consideration.

The instrument represented by the accompanying wood-cut has, with me, proved a most valuable resource in the treatment of chronic metritis, and as such I commend it to the profession. The engraving shows a long pipe (a) attached by a friction plug-joint (b) to a small piston-

syringe. This pipe terminates in an expanded bulb, and is grooved on four sides, as shown at (g), which represents the exact size of a part of the tube. The bulb is pierced obliquely on its sides, and may be unscrewed from the pipe and a larger bulb adjusted if desired.

When a fluid is forced from the syringe through the pipe it escapes through the small openings of the bulb, and flows obliquely backward toward the operator. The bulb slightly dilates the passage, while the grooves favor an immediate escape of the fluid, thus enabling us to give a true intra-uterine douche. The remedy that has given me the most satisfactory results in these cases is the distilled extract of Hamamelis Virginica, used without dilution, once a day. With this instrument and this remedy I have cured cases that have long resisted the usual methods of treatment.

The other pipes figured in the cut are intended for other purposes. The tube (c), having a sharper curve than is here represented, is for sprinkling the posterior nares. The instrument (made for me by Codman and Shurtleff, of Boston) is entirely of hard rubber, and the pipes may be bent to any desired curve by carefully heating them. The device is simple, compact, comprehensive, and cheap.

RECENT PROGRESS IN GENITO-URINARY SURGERY.

BY THOMAS B. CURTIS, M. D.

Treatment of Rupture of the Urethra. — Mr. Teevan[1] publishes two cases of retention of urine from laceration of the urethra treated by catheterism with good results. In the first case, that of a boy aged seven years, an elastic olivary catheter having previously failed to enter, a metal catheter was successfully introduced by following the upper wall of the urethra, which was undamaged and served as a guide; the instrument was tied in for twenty-four hours. In the second case the patient, aged thirty, having been kicked in the perinæum, lost blood from the urethra and experienced retention of urine; an olivary elastic catheter of medium size was easily passed, and withdrawn after evacuation of the urine; a similar instrument was passed and tied in a few hours later, and was retained two days. Mr. Teevan, in his remarks on these cases, recalls that Mercier had laid it down as a rule that if a laceration or false passage existed in the floor of the deep portion of the urethra, a curved metallic catheter ought to be passed, as it could be made to hug the roof of the urethra; if, on the contrary, the laceration were in the roof, a straight elastic catheter ought to be passed, to keep to the floor of the urethra. "Inasmuch as in the case of the boy a metal catheter only could be introduced, it proved that the ure-

[1] The Lancet, August 21, 1875.

thra had been torn in its floor, whilst the fact of an elastic catheter only being able to be passed in the man showed that the urethra had been torn in the roof. . . . The cases showed that soft and metal catheters had each its sphere of action, though, as a rule, if the urethra were completely torn across, a small olivary catheter would be found more likely than any other instrument to pick up the distal end of the divided canal." Mr. Teevan brings forward Mercier's rule as a guide for the surgeon in his choice of procedures. But in his own cases, as his words show, the locality of the incomplete laceration of the urethra was only determined by means of the results following attempts, unsuccessful and successful, to pass various instruments, and it seems to us that this must always be the case. Therefore Mercier's propositions can at best only serve in such cases to explain the mechanism of successful catheterism, and can afford no clew by which to recognize the operative indications.

M. Notta[1] (of Lisieux) brought up the subject of the treatment of ruptured urethra before the Surgical Society of Paris with three cases which had been successfully treated by incision of the perinæum, after failure of attempts to introduce a catheter. He lays down as a rule that, in cases of ruptured urethra, the surgeon should first try to introduce a catheter, with a view to keeping it tied in; and that, failing in this attempt, he should immediately practice external perineal urethrotomy. He thinks that subsequently, after a period of three to eight days, it is advisable to tie in a catheter, "to reëstablish the continuity of the canal." For this purpose Notta uses a vulcanized rubber catheter, which he introduces by the assistance of a long, filiform, whalebone bougie, serving as a conductor. M. Guyon, on the other hand, is of the opinion that attempts at catheterism are extremely likely to be not only fruitless but positively injurious. He advocates the immediate performance of external urethrotomy without a conductor, which, he says, is an easy operation in cases of recent traumatism, however difficult it may be in cases of inveterate stricture accompanied by fistulous tracts. Guyon also ties in a catheter, but this he does immediately after practicing the median perineal incision.

The Operative Means for the Relief of Patients suffering with advanced Prostatic Disease. — In certain cases of obstructive hypertrophy of the prostate which have long necessitated the frequent use of the catheter, an advanced stage finally arrives which is associated with a great diminution of the capacity of the bladder, so that the artificial evacuation of the urine has to be repeated from sixteen to twenty-four times or more in the twenty-four hours. This is a condition of extreme misery for the patient, and often of peril, from the risk of injury in the frequently repeated performance of catheterism. The employment of an in-lying catheter, on the other hand, is at best but a temporary rem-

[1] Gazette hebdomadaire, June 4, 1875.

edy. In such cases Sir Henry Thompson[1] proposes to puncture the bladder above or rather behind the pubes, with a view to establishing a permanent outlet for the urine through an in-lying canula. The proceeding, which he has practiced in three cases, resembles the high operation for stone, rather than the ordinary supra-pubic puncture as practiced in cases of retention, since in the cases described, the bladder, instead of being distended with fluid, is nearly empty, retracted, and perhaps displaced and deformed by the prostatic growth. The first step of the operation consists in passing a large, strongly-curved, hollow sound containing a long bulbous-ended stylet. The instrument is introduced by the urethra until the end can be felt just behind the symphysis pubis. It is then confided to an assistant. The operator now makes an incision not more than three quarters of an inch in length, less if the patient is not stout, enough to admit the index-finger tightly, in the median line at the upper margin of the symphysis. The tissues are separated by the finger, and the linea alba being next slightly divided by the point of a bistoury, the finger is passed down closely behind the symphysis, and when the end of the sound is clearly felt a little opening is made so as to expose its point. The operator now, taking the handle of the sound in his left hand, makes the end protrude in the wound, and withdraws the bulbous stylet; taking then a short, curved canula of elastic gum, with a silver plate at its distal extremity (somewhat resembling a tracheotomy canula), the surgeon passes it into the hollow channel of the sound. He now withdraws this completely by the urethra, and in doing so insures the passage of the elastic canula into the bladder. The canula is then to be fastened securely with tapes and plaster, and must be worn a few days in bed, until the parts are consolidated and the patient can move about with safety. If the tube escape during the first two or three days it may not be easy to replace it, but it can be removed and replaced easily enough when the passage is established. A very important point is to make the wound as small as possible, so as to be nearly filled by the canula. Three cases are briefly reported. In two of them the operation was adopted solely as a last resource, to mitigate the sufferings of patients whose fate was already sealed. In the third case the operation was performed at an earlier period, with the view of prolonging life. Unluckily, on the third or fourth night the canula escaped, the house-surgeon was unable to introduce it, and extravasation took place; the patient died four months later. Sir Henry Thompson says, in conclusion, that the operation itself, properly performed, makes little or no demand on the patient's powers, and that he shall no doubt give it further trials, as he has faith in its utility for appropriate cases.

[1] The Lancet, January 2, 1875.

The Treatment of Chronic Cystitis by Means of Artificially Produced Incontinence of Urine. — The procedure just described is designed to relieve ceaseless vesical tenesmus, due to an incurable disease, by establishing a permanent outlet for the urine. The function of the bladder as a reservoir requiring intermittent evacuation is thus permanently superseded. The various methods of treatment now to be alluded to are somewhat analogous in design, their common object being to keep the bladder constantly empty for a time, by means of the temporary induction of incontinentia urinæ, either through the natural channel (the dilated female urethra), or through an artificial opening (vaginal cystotomy in females; perineal cystotomy in males). The credit of having first suggested this treatment of chronic cystitis appears to belong to Dr. Sims, who proposed it in 1858 to Dr. T. A. Emmet. The latter has since that date frequently and successfully treated chronic cystitis in the female by vaginal cystotomy, the opening into the bladder being artificially kept open as long as appeared necessary.[1] Professor Willard Parker[2] published in 1867 a paper on cystitis in the male treated by cystotomy, with cases; his operations were performed in 1846 and 1850.

T. Pridgeon Teale[3] has during the last eight years frequently treated vesical irritability in the female by dilatation of the neck of the bladder, with absolute cure in about a third of thirty or forty cases so treated by himself and his friends. His procedure consists in slowly distending the urethra by means of Weiss's dilator, until it admits two fingers. In many cases so treated some laceration occurs, causing after-pain during a day or two; often the intended incontinence did not ensue, but the tenesmus was relieved, the result being analogous to that produced by dilatation of the sphincter ani in painful fissure; in other cases incontinence lasted a few weeks; in one case it lasted several months; and in two cases, permanent incontinence ensued. "It does not, however, appear that the liability to permanent incontinence depended upon the degree to which the dilatation was carried." In three cases death occurred shortly after the operation, but advanced disease of the kidneys was found to exist.

Dr. T. W. Howe[4] published a case of cystitis occurring in a female, successfully treated by dilatation of the neck of the bladder. By various means, instrumental and digital, the urethra was dilated until a glass speculum nearly three quarters of an inch in diameter could be introduced. The urine dribbled from the bladder until the fifth day, when the sphincter resumed control. A rapid and complete cure of

[1] See an article in the American Practitioner for February, 1872.
[2] See Transactions of the New York State Medical Society, 1867.
[3] The Lancet, November 27, 1875.
[4] The Medical Record, August 14, 1875.

cystitis, which had resisted other treatment over two months, resulted from the dilatation.

Want of space forbids our making more than a mention of the analogous treatment of inveterate cystitis in the male. In such cases cystotomy has been performed by Willard Parker, Velpeau, Syme, Dolbeau, Bickersteth (of Liverpool) Battey (of Georgia), Prof. E. Powell (of the Rush Medical College), Parona, and many others.[1] The disposition of the male parts of course renders this treatment of cystitis more difficult than it is in the female, where the neck of the bladder is relatively easy of access. A median cystotomy is generally performed, or else, after a perineal urethrotomy, the prostatic urethra is dilated, as in Dolbeau's operation for stone.

Rapid Dilatation of the Female Urethra. — Among other methods for rendering the female bladder accessible for diagnostic or therapeutic purposes, Professor Simon,[2] of Heidelberg, has carefully investigated this time-honored procedure, and has laid down accurate rules for its rapid, efficacious, and innocuous accomplishment. The operation was an old one, but our knowledge of the extreme limits of safe dilatation of the female urethra was very uncertain, nor was the proper *modus operandi* established until the publication of Simon's researches. In order that we might be able to produce the maximum dilatation of the urethra without causing laceration or subsequent incontinence of urine, it was necessary that we should know with tolerable accuracy the consequences which might be anticipated from extreme degrees of dilatation properly conducted.

Simon uses for dilatation a series of smooth, hard-rubber, conical plugs, whose diameters are graduated by intervals of one millimetre, the smallest being three quarters of a centimetre, and the largest two centimetres in diameter; thus the largest plug has a circumference equaling 6.3 centimetres, and is about as thick as the forefinger. These plugs are preferable to all other dilating agencies, such as the fingers, various forceps, and many-branched dilators, inasmuch as by their means we can accomplish rapid dilatation with the least possible risk of laceration or injury to the peri-urethral tissues. Anæsthesia being established, for the operation is otherwise very painful, the first step consists in slitting the external meatus, which is the narrowest part of the urethra; three small slits, two above laterally, of a depth of one fourth of a centimetre, and one below, of a depth of one half of a centimetre, suffice for all purposes, and are harmless. The plugs being then successively inserted, up to the largest, it becomes easy to introduce the forefinger, and if at the same time the precaution is taken of passing the medius into the

[1] See the British and Foreign Medico-Chirurgical Review, January, 1875, page 243; also the American Journal of the Medical Sciences, April, 1875; also Professor Dolbeau's Leçons de Clinique chirurgicale.

[2] See the New York Medical Journal, October, 1875.

vagina, almost the entire length of the forefinger can be utilized for intra-vesical manipulations.

The limits of dilatation are as follows: In adult women, plugs 2 centimetres (.8 of an inch) in diameter, 6.3 centimetres (2.4 inches) in circumference, can be used without detriment; in sufficiently urgent cases, dilatation may be carried up to a circumference of 6.5 to 7 centimetres (2.5 to 2.7 inches) without the production of any lasting inconvenience. Beyond this latter limit, however, Simon asserts that dilatation would entail a risk of permanent incontinence. In girls aged from eleven to fifteen years, the highest degrees of completely innocuous dilatation seem to be reached when a circumference of 4.7 to 5.6 centimetres (1.78 to 2.14 inches), equaling diameters from 1.5 to 1.8 centimetres (.54 to .63 inch), has been attained. In girls from fifteen to twenty years of age, the maximum circumferences range from 5.6 to 6.3 centimetres (2.14 to 2.45 inches), equaling diameters from 1.8 to 2.0 centimetres (.63 to .78 inch). In exceptional cases, justifying the infliction of temporary incontinence, the limits so fixed might be slightly exceeded.

The urethra having been so dilated as to admit the forefinger, it becomes possible to execute a very complete exploration of the bladder, especially by means of the bimanual method of palpation; many operative procedures are also facilitated, and new operations are rendered possible. The indications for the employment of Simon's dilatation of the female urethra are set forth as follows: (1.) The diagnosis of diseases of the mucous membrane of the urethra and bladder, by digital exploration, and by endoscopic examination. (2.) The diagnosis of calculi and foreign bodies. (3.) The extraction of such bodies. (4.) The application of caustics in certain affections of the bladder. (5.) The treatment of fissures of the urethra. (6.) The diagnosis of defects in the vesico-vaginal septum, when the vagina is closed. (7.) The diagnosis of the seat and extent of growths and tumors in the vesico-vaginal septum. (8.) The extirpation of tumors, especially of papillomata, from the mucous surface of the bladder. (9.) The discovery and extraction or excision of renal calculi from the vesical part of the ureter. (10.) The opening of hæmatometra in certain cases. (11.) The cure of colo-vesical or entero-vesical fistula by cauterization of their vesical orifice.

WAGSTAFFE'S HUMAN OSTEOLOGY.[1]

THOUGH any great work on anatomy that can stand on a level with Henle's is still to be written in the English language, we are singularly rich in treatises on osteology. Beside the descriptions of the bones in the text-books, we have three well-known works: Ward's, Humphry's, and Holden's. The oldest is that of Ward, and in some respects it is still the best; it combines a most accurate and minute description of the bones with many very original observations expressed very clearly and briefly. The author opened a new road in English anatomy, and if some subsequent books are as good as his it is greatly owing to him. Holden's book is undoubtedly the most popular among students, a fact due chiefly to its fine plates and easy style, though we think it decidedly inferior to either of the others. Humphry's Human Skeleton is not meant as a text-book, and the descriptions are consequently wanting in minuteness, but it abounds with scientific and practical observations. The joints are considered as well as the bones, and their actions are treated in a masterly manner. It is to our mind the best of the three. With such predecessors it is no easy task to write a new treatise on osteology. Pretty nearly all the facts concerning bones have been noted, and there remains only the method of handling the subject that offers scope for originality. This field is, however, immense, and will never be exhausted. Mr. Wagstaffe has seized the only road that is still comparatively untraveled, that of the internal structure of bones, and has written a good deal that is good and new, but still we are inclined to regard this part as a failure, owing to his profound ignorance of the literature of the subject. There is no mention of Wyman's law of studs and braces, of Bigelow's "true neck of the femur," or of the investigations of several German authorities, an acquaintance with which would have saved the author some errors.

This being said, we have nearly done with criticism. The description of the coarse appearance of the bones is for the most part very good, and the recapitulation of the points of importance at the end of each section will serve to impress them upon the student. The plates are finely executed and very good, most of them being in the style of Holden's, and having colored lines to indicate the origin and insertion of muscles. We are somewhat in doubt whether too much is not said on this subject, but it is hard to draw the line, and if the pruning knife were used at all it would have to be wielded by a very careful hand lest it take what could not be spared. A great deal of the mechanism is very excellent. We are glad to see a chapter on the bony landmarks that can be felt during life. There are few books on any subject that reach the ideal of the special critic, owing to the fact that no two minds view a subject from precisely the same standpoint. Further criticism might, no doubt, be made on many points, but when we consider the great difficulty of saying just enough without overdryness or too much diffuseness, we must admit that the work reflects great credit on the author, and we can heartily recommend it.

T. D. JR.

[1] *The Student's Guide to Human Osteology.* By W. W. WAGSTAFFE, B. A., F. R. C. S. Philadelphia: Lindsay and Blakiston. 1875.

LEISHMAN'S SYSTEM OF MIDWIFERY.[1]

The simultaneous demand, both in England and in America, for a second edition of this work attests sufficiently its value. Essentially the book remains the same, but it is to be especially noticed that the author has greatly changed the two chapters on puerperal fever. When the book first appeared we criticised the ideas held on that subject as being far behind the times. In the present edition we think we recognize the first fruits of that remarkable discussion which has recently taken place before the London Obstetrical Society. The author now gives up the idea of a specific puerperal poison, and considers that the character of the disease is due, not to anything specific in the cause, but to the peculiar physiological condition under which the puerperal woman lies. He believes that the fever is mainly generated by septic absorption, and that the poison of any of the specific eruptive diseases may give rise to an affection which usually offers clear evidences of the puerperal type of the febrile disease, while at the same time it may retain more or less of the specific characteristics of the disease from which it was engendered.

Some changes have also been made in the physiological section of the work, and the author has added considerable valuable matter as to the causes of sudden death in the puerperal state, a subject not alluded to in the previous edition. Additional stress is laid upon Credé's method of managing the expulsion of the placenta, which the author advises should always be adopted.

Copious notes to the English edition have been added by Dr. Parry, of Philadelphia, who has also introduced a few new illustrations, representing for the most part the principal modifications of obstetrical instruments generally employed in this country. We must confess that we are not fond of this method of interpolating critical notes. If, however, it is to be done, then it is a matter worth noticing that it has in this case been well done. Especially valuable is the chapter on the diphtheria of puerperal wounds, which Dr. Parry has added entire, and which was originally published in the *American Journal of the Medical Sciences*, January, 1875.

This second edition of Dr. Leishman's work, taken as a whole, is a great improvement on the first.

PROCEEDINGS OF THE OBSTETRICAL SOCIETY OF BOSTON.

CHARLES W. SWAN, M. D., SECRETARY.

October 9, 1875. The president, Dr. Hodgdon, in the chair.

Hysterotomy. — Dr. Chadwick reported a case of hysterotomy for a fibroid tumor, exhibiting the specimen. The case was published in the Journal of November 4, 1875.

Dr. Lyman, referring to the tetanus with which the subject of the operation died, asked what had been the treatment of the pedicle in other cases.

[1] *A System of Midwifery.* By William Leishman, M. D. Second American, from the second and revised English edition. With Additions by John S. Parry, M. D. Philadelphia: Henry C. Lea. 1875.

Dr. Chadwick replied that it was Péan's practice to fix the pedicle in the abdominal wound. Dr. Chadwick considered that hysterotomy was somewhat more dangerous than ovariotomy, owing to the greater shock to be expected from the removal of so important an organ as the uterus, and to the greater liability to hæmorrhage. These dangers are in a measure offset by the rarity of adhesions with fibroids; this remark does not apply, however, to fibro-cysts. Péan has lost but five out of his twenty cases; the causes of death were hæmorrhage, shock, and septicæmia; some of the tumors were universally adherent.

In answer to a question, Dr. Chadwick stated that the sound could not be passed beyond the internal os until the cervix had been dilated; an elastic sound then passed to the fundus without pain. He described the gas cautery invented by Dr. Bruce, of London, which in the hands of Dr. J. Homans had proved so efficient in checking the hæmorrhage. A conical hood of platinum was heated by means of a gas jet blown into it. The only drawback to its use was the tendency of the flame to spread about and beyond the cone, thus endangering the tissues for some distance around the point to be cauterized; otherwise the instrument had proved very useful and convenient.

Fatal Hæmorrhage from Extra-Uterine Fœtation. — Dr. Driver reported the case. He was called in the night to see the patient with Dr. Hildreth. The woman was apparently in collapse, — gasping, restless, in cold perspiration, white, pulseless, and in intense pain low down in the abdomen. She was quite rational. On examination of the abdomen he found a region of dullness on the right side in the pelvic region, limited on the left by an oblique line which extended from the symphysis pubis upward and outward to the right hypochondrium; all the rest of the abdominal surface being resonant. The diagnosis was accidental internal hæmorrhage.

The woman had gone over one menstrual period, and, suspecting pregnancy, had on the day of the visit taken tansy twice. At eleven P. M. she had gone to bed feeling quite comfortable. She had had one or two dejections. She was awakened by severe abdominal pain. For a while there seemed to be some improvement; the pulse came down to 130, and at this time she had two loose dejections, and felt easier; but before four A. M. the patient was dead, death being preceded by symptoms of renewed hæmorrhage. An autopsy showed a large clot occupying the whole region of dullness previously defined. There was an enlargement of the left Fallopian tube, about half an inch from the body of the uterus, containing an ovum of the size of a filbert; and this dilated portion was found to be ruptured posteriorly and upward. Hence the whole fatal hæmorrhage. In answer to questions, Dr. Driver said that he found all the characteristics of an ovum except the fœtus. The pain was continuous, but with exacerbations.

Dr. Lyman said that he had had, about fifteen years ago, a similar case. Dr. Hooker also reported a case of tubal pregnancy, with rupture and fatal hæmorrhage. In his case, the patient, a young woman not quite three months pregnant, had precisely the same symptoms, and the diagnosis was the same as in the present instance. She lived about three hours. The diagnosis was verified by an autopsy made by Dr. Ellis. Lately Ziemssen has spoken of external

hæmorrhage as always present; this, Dr. Lyman remarked, is not so. Dr. Lyman once collected eleven cases which had been at different times reported to the Boston Society for Medical Improvement, and in only four of these was external hæmorrhage present.[1]

Dr. Ingalls reported a case which he had had fifteen or eighteen years ago. He saw the patient not more than fifteen minutes before she died, but from the symptoms he diagnosticated tubal pregnancy and hæmorrhage. There was no post-mortem examination.

Dr. Lyman remarked that the pain in these cases is peculiar and agonizing; he likened it to the pain from gun-shot wounds of the pleura or the abdomen, in which the blood flows over an uninflamed serous membrane.

Dr. Stedman reported a case which he had seen a few years ago with Dr. Fifield, in which the symptoms of the patient, six months pregnant, were abdominal pain, pallor, collapse, and death. An autopsy revealed a normal pregnancy. The symptoms had been due to the rupture of a small vessel in the neighborhood of the liver. The precise locality of the pain was not noted.

Dr. Sinclair asked how the pain in these cases could be distinguished from that of pelvic hæmatocele. He had had a recent case of hæmatoma in which the symptoms were very similar to those above described.

Dr. Driver said that in the case reported by him there was at once a rapid hæmorrhage extending over a large surface of the peritoneum, and the symptoms were proportionately severe. He thought that as a cause of pain the difference was considerable between a split of a Fallopian tube and the puncture of a vein. Moreover, in an hæmatocele the hæmorrhage is often subperitoneal.

Dr. Chadwick said that it seemed hardly justifiable to find fault with a diagnosis which had proved correct, yet he could not see that the symptoms were so unequivocal as to point at so rare a condition as extra-uterine fœtation, to the exclusion of hæmatocele, etc. He did not think that the suddenness of the attack, the severity of certain symptoms, the position and extent of the hæmorrhagic effusion, were, even when associated, pathognomonic of extra-uterine pregnancy; the patient's belief that she was pregnant should have but little weight in the first three months.

Dr. Driver replied that the diagnosis in the case reported was based upon the group of symptoms, physical and rational, which belonged to the case: the cessation of menstruation and suspected pregnancy, the suddenness of the attack, the agonizing pain, pallor, restlessness, and collapse, with absence of pulse, the locality of the pain, and the physical signs of large clot. This group of symptoms was best explained by the diagnosis actually made.

Dr. Chadwick reminded the society of the brilliant exploit recently performed by Dr. T. G. Thomas, who, having diagnosticated tubal pregnancy, extracted the fœtus through an incision made from the vagina into the sac with a white-hot knife; the patient made a good recovery.

Dr. Wellington recalled two cases which he had previously reported, in which there were symptoms of tubal pregnancy, with rupture of the tube and intense hæmorrhage. Both the patients recovered.

[1] Records of the Boston Society for Medical Improvement, November 28, 1859.

THE POMEROY CASE.

On the first of January, one year since Governor Gaston solemnly swore to enforce the laws of the commonwealth, the same oath will be taken by his successor. Let us hope that to him the oath will be something more than a string of words; that it will be to him an agreement the keeping of which is essential to his honor, the violation of which is perjury. Should he take this view, and we do not see how he can take any other, his course with regard to the murderer Pomeroy is clear. What are the facts of the case? The story of his atrocious crimes is sufficiently well known; let us begin with his trial. The defense made a desperate effort to make out insanity, a plea which was utterly overthrown by the evidence of Dr. Choate, of New York. The jury found him guilty, but (as we learn from good authority) one of their number preferred perjuring himself to taking the responsibility of bringing in a just verdict, and the others, to save him from this crime and to bring about an agreement, added a recommendation to mercy to their verdict. This recommendation was made the most of by those whose delicate sensibilities make them the friends of criminals and the enemies of society. At their instance a peculiar kind of mock trial was held by the governor and council, which they hoped would bring about a commutation of the sentence, but this, happily, the council refused to authorize. One would think that his oath left the governor no further freedom of action, no refuge from signing the death-warrant, but he calmly does nothing, and smiles while the community claims protection. We hope that the new governor will know his duty better, and there is one point to which we would call his attention. The question of insanity does not concern him; this was settled at the trial, and should not be reopened. It is making a mockery of justice to re-try the case, which has been legally decided. To those interested in the criminal as a psychological problem we recommend the admirable article by Dr. C. F. Folsom that we publish to-day; it shows clearly Pomeroy's accountability. If the sentimentalists carry the day we may look for quite an epidemic of this form of "insanity," but if justice and reason triumph it will be shown that a little hanging is an excellent prophylactic.

THE HOMŒOPATHIC RAID.

A bold attempt has been made by the homœopaths to obtain a foothold in the City Hospital. A petition was presented, a hearing took place at the City Hall, and the matter was referred to a committee, which in due time reported that two schools of medicine could not work together, and gave the petitioners leave to withdraw, but singularly enough recommended that such patients as preferred to go to the homœopathic hospital should be to a certain extent paid for by the city. This recommendation is, on the whole, a triumph for the petitioners. This is the small end of the wedge, the beginning of a plot by which this particular set of irregulars propose to win an endowment for their hospital. Why they should be favored more than any other set of practitioners, we are at a loss to see. Natural bone-setters, praying doctors, spiritual

doctors, corn-cutting doctors, have but to establish the similitude of a hospital, if they have not one already, and they may with equal justice request permission to introduce their hands into the public pocket. The principle upon which the claim is made is entirely false; the government cannot take into account old women's preferences for this or that "pathy," but must intrust its institutions to those whose membership of the Massachusetts Medical Society is a guarantee of respectability and competence.

MEDICAL NOTES.

— The proposition of Mr. Marshall to institute a compulsory examination in anatomy at the end of the first winter session of the metropolitan medical schools has occasioned considerable discussion on the part of our English exchanges. Of the candidates who present themselves at the primary examination for the membership of the College of Surgeons, Mr. Marshall alleges, according to *The Lancet*, "that some pass extremely well, some barely succeed, whilst the remainder are so deficient in knowledge, especially of anatomy, that they have to be referred for further study, though they have arrived at least at the end of their second year." At the pass examination "a very large proportion of candidates retain a quite insufficient knowledge of anatomy, often forgetting even the most simple and essential facts in that science."

While these statements of Mr. Marshall seem to be admitted as true, the causes assigned by him of the lack of knowledge on the part of the candidates, namely, their mental incapacity and their want of proper training, are not so readily acknowledged. One cause assigned by *The Lancet* is the scanty and irregular supply of subjects for the purposes of dissection, so that at the present time in London many students, both first and second year, must remain idle for want of the opportunity to dissect. In fact, to such an extent is this scarcity of subjects felt by the medical students themselves that they write letters of complaint to the medical journals. A correspondent referring to the proposition of Mr. Marshall attributes the unsatisfactory preparation of candidates to the fact "that men are allowed, and even required, to attend hospital practice and lectures on the practical subjects, while they are working in the dissecting room and physiological laboratory. . . . The majority of students adopt the plan of crushing through all their hospital practice and lectures in two years and a half, or at most in three years, and present themselves badly prepared for all their examinations."

So common has it been for the opportunities afforded by the medical schools of this country for the obtaining of a thorough medical education to be disparagingly spoken of by many of the English journals, when compared with the advantages presented by their own, that we confess to have read with some surprise the statements which Mr. Marshall's proposition has called forth. They tend to confirm us in the belief that the method now pursued at the Harvard Medical School, of carrying the student progressively and systematically from one subject to another in a just and natural order, is the true one.

— Sir Robert Christison, the president of the Edinburgh Botanical Society, made, according to the *British Medical Journal*, from which we quote, some rather surprising statements concerning the "coca leaf," which, it is to be remembered, is not the same as cocoa. "In Peru, where it grows, coca is reported to have remarkable nourishing properties; and, in order to ascertain the precise nature of these, he chewed the leaf by way of stimulant on the occasion of two ascents of Ben Voirlich. On reaching the top, he felt greatly fatigued, and began to chew his coca; with the result that he was able to make the descent, not only with firmness, but with almost juvenile elasticity. He further stated that by its use he had found himself able to walk sixteen miles with ease, although when he attempted this feat without such nourishment he felt greatly fatigued."

— The large number of new editions of text-books of physiology is a sign of the activity of competition between both physiologists and publishers. The result cannot but be very beneficial to the student, for in this struggle for existence there can be no doubt of the ultimate survival of the fittest. We are inclined to think that the success of Dr. Amory's translation of Rüss' admirable handbook has had a great deal to do with this rivalry. Its success was so great that it became necessary to bring Dalton's book up to the times and to reduce Flint's great compilation to a manageable compass A new edition of Carpenter is also announced, and we see that Dr. Gamgee has just translated the fifth edition of Hermann.

CONCERNING THE EXECUTION OF CRIMINALS.

"THE rope had not been properly arranged around his neck, and scarcely had he been hoisted into the air when he gave unearthly screams, and, writhing in terrible agony, clutched the rope with both hands, notwithstanding they were bound, and, drawing his body up, cried, 'Save me!' His tortures seemed terrible. Three times in succession he raised himself up, to the horror and surprise of the spectators, and finally by his own efforts succeeded in adjusting the rope properly around his neck. He then soon ceased to struggle."

The above is not an extract from the records of the inquisition, nor a quotation from some of the dark chronicles of the Middle Ages, but an account taken from the daily papers, of what took place in the city of New York on the 17th of December in the year 1875 of the Christian era. That such an occurrence is to be deprecated and deplored no one will doubt; and the question as to whether there is any necessity for it naturally presents itself.

An argument on the subject of capital punishment in the abstract would be entirely out of place in this connection; it is sufficient that our law-makers have decided that in the present state of society it is necessary; but let us see what is its object and how it is fulfilled. Its object is threefold: (1) to remove a dangerous character from the society of his fellow-beings, and make sure that he can do no further harm; (2) to have the most severe penalty attached to the commission of crimes which would interfere with the safety and well-being of society, and thus frighten people from committing them; and (3) to

show the criminal classes that such crimes are followed by punishment, or, in other words, to serve as an example. That the first of these objects could be attained by the killing of the offender in any way cannot be denied, and in all probabilities likewise the second; for it is inconceivable that the penalty of death could be made enough more fearful by the addition of physical suffering to it, to deter any one from the commission of a crime which the fear of simple death would not restrain him from. If this is not the case, society certainly owes it to itself to draw and quarter, burn and flay alive, those who commit certain atrocities.

With regard to the third object there may be more difference of opinion, but it is pretty generally conceded that the public executions of the past did not fulfill it, as it was found that the idea of being at some future time, when his day had come, the central figure and hero of such a festival and merry-making as he had often joined in was not a very terrible one to the hardened criminal, but rather the reverse.

What does the sentence "and be hanged by the neck until dead" imply? It implies that a man shall stand up on a scaffold before some two or three hundred of his fellow-beings, shall listen to certain religious ceremonies spun out to a greater or less length according to the taste or humanity of the officiating clergyman, shall stand with a bag over his head, his arms and legs pinioned, a rope around his neck, and when the word is given shall be choked to death, dangling in the air in convulsive struggles, and evidently, for a certain space of time at least, suffering inconceivable tortures. It is true that theoretically his neck should be dislocated by the sudden jerk, and that pressure on the medulla should produce instant death. But in the vast majority of cases this does not take place, and the poor wretch dies of asphyxia produced by his own weight pulling on his throat. Twice have I witnessed such a spectacle, and twice have I come away ashamed of myself, ashamed of the spectators, ashamed of the officials, and ashamed of the state of society which allows such a relic of barbarism to still exist. If it had been a mere morbid curiosity that sent me there, this feeling of shame would have been natural; but it was not that; it was the same feeling that has kept me up all night at the bedside of a moribund patient, namely, the desire to witness the different phases of that awful mystery, the extinction of the vital spark.

And as if this was not bad enough, we have once in a while reports of such scenes as the one that called forth these few lines, or the rope breaks and the victim has to be hung over again, or the knot does not slip and the sheriff has to add his own weight to hasten the death of the struggling wretch, or at the last moment the criminal breaks down in an agony of fear and has to be dragged shrieking and struggling to the halter. This is horrible and degrading to all concerned, although if it is absolutely necessary for the carrying out of the law it must be accepted; but that is just the question — is it necessary?

There is no doubt that the sudden separation of the brain from the centre of circulation, as it is done by the guillotine, is a much quicker and more merciful method of execution than hanging, for the moment that the arteries which carry blood to the brain are severed, consciousness must cease. But this is a French method of execution, contrary to all the customs and tradi-

tions of the Anglo-Saxon race, and nothing short of a general revolution of feeling in the people could bring about the change. Is there, however, no way in which, without altering or interfering with the laws and customs that have come down to us from our forefathers, we can make the death-penalty less revolting and degrading to the assistants and spectators, to say nothing of making it less barbarous to the victim? Why should not the convict at the last moment be put under the influence of an anæsthetic? The occasion would not be any less solemn and impressive, rather the reverse. Suppose that the prisoner be seated in a chair under the gallows with the rope about his neck; after the reading of the sentence, etc., a physician should step up behind him and put a sponge with chloroform over his face. Let the clergyman's voice praying for mercy for his soul be the last human sound he hears as he goes off into his last sleep. In a few seconds the physician gives the sign, the weight falls, the unconscious sinner hangs with a few reflex quiverings, and the sentence of the law has been executed, literally and fully.

It is no morbid pity for the criminal that prompts this suggestion, but rather a desire to spare those who have to be present and the public who read the reports of the execution the feeling of shame and degradation which any one who is not without all delicacy of feeling must experience on witnessing a fellow-creature being slowly strangled to death.

The points that I have wished to call attention to in this hurried communication may be briefly recapitulated as follows. Hanging as now carried out is always painful to the victim and disagreeable to the assistants; sometimes it is torture to the former and degrading and revolting to the latter. By chloroforming the convict at the last moment these objectionable features would be eliminated, the fear of capital punishment would not be diminished thereby, the impressiveness of the occasion would be increased, and the literal fulfillment of the law would be complied with. Let Massachusetts take the initiative in this matter, and the whole civilized world will follow. F. B. G.

[Though this subject is not a strictly professional one, it is not, we think, out of place in a medical journal, especially as the plan proposed by our correspondent would bring members of our profession into immediate connection with executions. We do not agree with our correspondent for several reasons: in the first place, such accidents as the recent one in New York are utterly inexcusable and unnecessary; secondly, although the neck is rarely broken, we think it a pure assumption that death by judicial hanging is a very painful one; this point, however, may be put aside, for it is of very secondary importance whether the murderer suffers by his punishment or not; thirdly, it is as degrading to the spectators to see a man killed in one way as in another; and lastly, we doubt if the administration of chloroform would render impossible scenes of the greatest horror for all concerned. We can hardly imagine one more fearful than that of the weak-minded but able-bodied criminal struggling against the administration of the anæsthetic, being gradually overpowered by numbers, freeing his face, it may be, to shriek out blasphemies, and finally, a limp, unconscious mass, being dropped to the end of a rope in accordance with merely the letter of the law. — Eds.]

WEEKLY BULLETIN OF PREVALENT DISEASES.

The following is a bulletin of the diseases prevalent in Massachusetts during the week ending December 25, 1875, compiled under the authority of the State Board of Health from the returns of physicians representing all sections of the State: —

The summary for each section is as follows: —

Berkshire: Bronchitis, influenza, whooping-cough.

Valley: Pneumonia, bronchitis, influenza, diphtheria. More diphtheria reported. Shelburne Falls reports cases of small-pox imported from Northampton.

Midland: Influenza, bronchitis, pneumonia, rheumatism, diphtheria, typhoid fever.

Northeastern: Bronchitis, influenza, diphtheria, pneumonia. More diphtheria reported. Not much sickness.

Metropolitan: Bronchitis, scarlatina, diphtheria, pneumonia, rheumatism. Less diphtheria and scarlatina reported.

Southeastern: Bronchitis, influenza, scarlatina, rheumatism. More scarlatina and diphtheria reported.

In the State at large the order of relative prevalence of diseases is as follows: Bronchitis, pneumonia, influenza, diphtheria, rheumatism, scarlatina, typhoid fever, croup, measles, diarrhœa, whooping-cough; only the first six deserve mention. Diphtheria has increased; other diseases have declined.

F. W. Draper, M. D., Registrar.

COMPARATIVE MORTALITY-RATES FOR THE WEEK ENDING DEC. 18, 1875.

	Estimated Population.	Total Mortality for the Week.	Annual Death-Rate per 1000 during Week
New York	1,060,000	492	24
Philadelphia	800,000	326	21
Brooklyn	500,000		
Chicago	400,000	132	17
Boston	342,000	169	26
Cincinnati	260,000		
Providence	100,700	34	18
Worcester	50,000	12	12
Lowell	50,000	18	19
Cambridge	48,000	12	13
Fall River	45,000	19	30
Lawrence	35,000		
Lynn	33,000	10	16
Springfield	31,000	16	27
Salem	26,000	12	24

Normal Death-Rate, 17 per 1000.

The Boston Society for Medical Observation. — A regular meeting of the society will be held on Monday evening, January 3, 1876. Dr. Boardman will report a case of ovariotomy.